HA-0059-0805p

TRANSMITTAL OF DELETIONS
STATE HEALTH BENEFITS - DIVISION OF PENSIONS AND BENEFITS
PO Box 299, Trenton, NJ 08625-0299

(Please see reverse side for instructions)

1. Employer #: _____ 2. Employer Name: _____ 3. County: _____ 4. Date: _____

5. Signature of Certifying Officer is required (*1st page only*): _____ 6. Page _____ of _____

7. Name of Employee to be Deleted Last, First, M.I.	8. Plan Term			9. Deletion Code & Date		10. Social Security Number	11. Ten or Twelve Month Employee	12. Date Coverage Terminates Month/Year
	A. Health	B. Pres. Drug	C. Dental	A. Code FLS DTR	B. Last Date of Employment			

Total Number of Deletions Submitted: _____

TRANSMITTAL OF DELETIONS

INSTRUCTIONS

This form must be filed before the 5th of the month
preceding the month in which coverage is terminated.

1. **Employer # -** Enter the employer number found on your State Health Benefits Report. (Example: 0350-0).

2. **Employer Name: -** Enter the name of the employer completing the form.

3. **County -** Enter the county in which the employer is located.

4. **Date -** Enter the date you are preparing this form (must be completed).

5. **Signature of Certifying Officer -** Sign only on the first page of the report. Statute provides that the certifying officer is responsible for submission of this information (must be completed).

6. **Page ___ of ___ -** Enter the page number and the total number of pages in the report.

7. **Name of employee to be deleted -** Enter the employee's full name (last, first, middle initial). Only names of employees who **are enrolled** in the State Health Benefits Plan and want to **terminate** coverage should be entered on this form.

   Do not enter new employees who reject/waive coverage. They must complete a *NJ SHBP Enrollment Application.*

8. **Plan Termination -** Please place an (x) the plan(s) to be terminated - Health and/or Prescription Drug, and/or Dental.

9A. **Deletion Code -** Enter the appropriate code. If termination immediately follows the end of a Family Leave, insert (F). For all other cases, insert the codes shown here. Leave of Absence (L), Sabbatical (S), Death (D), Termination for resignation, reduction in force, or reduction in hours (T) or for Retirement (R).

9B. Please enter the last day of employment or date of death.

10. **Social Security Number -** Enter the employee's Social Security number.

11. **Ten or Twelve Month Employee -** Enter **10** if the employee is reported as working 10 months a year. Enter **12** if the employee is reported as working 12 months a year.

12. **Date Coverage Terminates -** Indicate the month and year that coverage terminates. The termination is effective the first of the month following the first full month for which no salary was paid (if the employee is a 10-month employee who completed a full contract year, the termination date is September 1). If termination is the result of the employee's death, the termination is effective the first of the month following the date of death.

Mail the completed form to: State Health Benefits Bureau
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299